UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED
   DATE: **18-MAR-2013** TIME: **0845** HOURS

2. OPERATOR: **Apache Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:

4. LEASE: **00842**
   AREA: **WD** LATITUDE:
   BLOCK: **105** LONGITUDE:

5. PLATFORM: **E**
   RIG NAME:

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   - [ ] HISTORIC INJURY
   - [X] REQUIRED EVACUATION **1**
   - [ ] LTA (1-3 days)
   - [ ] LTA (>3 days
   - [ ] RW/JT (1-3 days)
   - [ ] RW/JT (>3 days)
   - [X] Other Injury **1** **Unknown**
   - [ ] FATALITY
   - [ ] POLLUTION
   - [ ] FIRE
   - [ ] EXPLOSION
   - LWC
     - [ ] HISTORIC BLOWOUT
     - [ ] UNDERGROUND
     - [ ] SURFACE
     - [ ] DEVERTER
     - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES
   - COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K
   - [ ] STRUCTURAL DAMAGE
   - [X] CRANE
   - [ ] OTHER LIFTING DEVICE
   - [ ] DAMAGED/DISABLED SAFETY SYS.
   - [ ] INCIDENT >$25K
   - [ ] H2S/15MIN./20PPM
   - [ ] REQUIRED MUSTER
   - [ ] SHUTDOWN FROM GAS RELEASE
   - [ ] OTHER

6. OPERATION:
   - [X] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] OTHER

8. CAUSE:
   - [ ] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER

9. WATER DEPTH: **237** FT.

10. DISTANCE FROM SHORE: **12** MI.

11. WIND DIRECTION: **SW**
    SPEED: **12** M.P.H.

12. CURRENT DIRECTION: **W**
    SPEED: **2** M.P.H.

13. SEA STATE: FT.

17. INVESTIGATION FINDINGS:

On 18-Mar-2013 at approximately 0848 hours, during a blind lift operation that involved offloading equipment from a Motor Vessel to the platform, a rigger positioning the load onto the deck was injured as a result of poor body placement and inadequate communication.

According to witness statements, the crane was making a blind lift requiring one (1) signal man and two (2) riggers to control the load (welding machine). The crane operator had to depend on the signal man's hand signals and radio communication because the load's final location was obstructed by a large storage container. BSEE observations indicated only one tag line was on the welding machine. It was noted in Apache's Loss Occurrence Report that one of the riggers yelled out to "Hold-up" meaning that he had not yet stabilized the load. However, the signal man did not hear him and gave the signal to the crane operator to lower onto the deck. As the load neared the deck, it was indicated by one rigger, that the other rigger attempting to control the load, bent over as the load passed between them to position the load as it came down. He then noticed a hard hat hit the deck as the load hit the deck. As he walked around the load, he noticed the other rigger sitting on the deck holding his head, saying that the machine came down on his head, jamming his neck down. He indicated that he jammed his head on the bar across the welding machine frame. After examining the load, it possibly was part of the frame built around the welding machine. The Loss Occurrence Report filed by Apache indicated that the Injured Person (IP) was taken to GI 43AA by boat for medical attention. Further examination deemed it necessary to send the IP in to a medical facility for further treatment.

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

1. The IP was in a pinch point.
2. Inadequate communication.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

The IP was:
1. Not being aware of his surroundings.
2. Not paying closer attention to his surroundings.
3. Only having one tag line on the load.
4. Lack of adequate communication between the riggers and the signal man.

20. LIST THE ADDITIONAL INFORMATION:

WD 105E was shut-in on March 17, 2013 for scheduled construction work and repairs. The projected completion date was April 4, 2013. As reported by Apache, the accident did not result in a loss time accident (L.T.A.)

Apache's recommendations to prevent recurrence:

1. Avoid pinch points.
2. Keep eyes on all areas of the load being controlled.
3. Use two tag lines.
4. Discuss during JSA procedures to provide adequate communication between riggers and signal man.

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District makes no recommendations to the Agency.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

21-MAR-2013

26. ONSITE TEAM MEMBERS:

Gerald Taylor /

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

David J. Trocquet

APPROVED DATE: **07-MAY-2013**

INJURY/FATALITY/WITNESS ATTACHMENT

[ ] OPERATOR REPRESENTATIVE
[x] CONTRACTOR REPRESENTATIVE
[ ] OTHER _____

[x] INJURY
[ ] FATALITY
[ ] WITNESS

NAME:

HOME ADDRESS:

CITY: STATE:

WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY: STATE:

ZIP CODE:

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